

1. REVISION DATE:  
MM / DD / YYYY

# MEMORANDUM OF PAYMENT

2. WCB FILE NUMBER  
(if known):

## EMPLOYEE

3. EMPLOYEE LAST NAME:		4. FIRST NAME:		5. MI.:	6. SOCIAL SECURITY NUMBER:		
7. STREET/P.O. BOX MAILING ADDRESS:		8. CITY:		9. STATE:		10. ZIP:	11. HOME PHONE NUMBER: ( )
12. DATE OF INJURY: MM / DD / YYYY		13. SPECIFIC INJURY OR ILLNESS:				14. BODY PARTS (S) AFFECTED:	

## EMPLOYER

15. INSURER FILE NUMBER:	16. EMPLOYER NAME:	17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:
18. INSURER/TPA NAME:		19.INSURER/TPA MAILING ADDRESS:

## NOTICE TO EMPLOYEE

20. YOUR EMPLOYER/INSURER IS REQUIRED TO FILE THIS WORKERS' COMPENSATION FORM UPON PAYMENT OF A LOST TIME WORK-RELATED INJURY. PAYMENT IS MADE FOR THE FOLLOWING REASON:

A. ☐ YOUR CLAIM IS ACCEPTED.  
B. ☐ THIS IS A VOLUNTARY PAYMENT PENDING INVESTIGATION.  
C. ☐ THIS IS A MANDATORY PAYMENT BECAUSE A NOTICE OF CONTROVERSY WAS NOT TIMELY FILED PURSUANT TO RULE 1.1.  
PERIOD COVERED BY MANDATORY PAYMENT: FROM (DATE) MM / DD / YYYY THROUGH (DATE) MM / DD / YYYY AMOUNT PAID \$ \_\_\_\_\_

21. TYPE OF PAYMENT:

A. ☐ WEEKLY COMPENSATION B. ☐ SPECIFIC LOSS \_\_\_\_\_ WEEKS AMOUNT PAID \$ \_\_\_\_\_  
C. ☐ PERMANENT IMPAIRMENT AMOUNT PAID \$ \_\_\_\_\_ D. ☐ OTHER (EXPLAIN) \_\_\_\_\_

22 A. IS THERE ANY INDICATION THAT THE INJURY IS PERMANENT? ☐ YES ☐ NO  
B. IF THE ANSWER IS YES, WHAT IS THE PERMANENT IMPAIRMENT RATING? % ☐ NOT YET AVAILABLE

23. DATE OF INCAPACITY: MM / DD / YYYY DATE EMPLOYER NOTIFIED: MM / DD / YYYY	24. DATE CHECK MAILED: MM / DD / YYYY	25. AVERAGE WEEKLY WAGE: \$	26. CURRENT WEEKLY COMPENSATION RATE: <input type="checkbox"/> TOTAL <input type="checkbox"/> PARTIAL \$
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27. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE NAME:	28. FIRST DAY OF COMPENSABILITY AFTER WAITING PERIOD IS MET: MM / DD / YYYY
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29. IS THIS AN APPORTIONMENT CLAIM? ☐ YES ☐ NO IF YES, ANSWER THE FOLLOWING:

OTHER DATE(S) OF INJURY INVOLVED: \_\_\_\_\_  
OTHER CARRIER(S) INVOLVED: \_\_\_\_\_  
WHO IS THE "LEAD" CARRIER? \_\_\_\_\_  
EXPLAIN THE TERMS OF THE APPORTIONMENT: \_\_\_\_\_

30. COMMENTS:

## ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

<b>AUGUSTA</b> 24 STONE ST. AUGUSTA, ME 04330-5220 (207)287-2308 (Voice) (207)287-6119 (TTY) 1-800-400-6854 (Voice)	<b>BANGOR</b> 106 HOGAN ROAD BANGOR, ME 04401-5638 (207)941-4550 1-800-400-6856	<b>CARIBOU</b> 43 HATCH DRIVE CARIBOU, ME 04736-2347 (207)498-6428 1-800-400-6855	<b>LEWISTON</b> 140 CANAL ST. LEWISTON, ME 04240-7777 (207)783-5490 1-800-400-6857	<b>PORTLAND</b> 62 ELM ST. PORTLAND, ME 04101-3061 (207)822-0840 1-800-400-6858
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31. CLAIM HANDLER NAME (TYPE OR PRINT):  E-MAIL ADDRESS:	32. TELEPHONE NUMBER: (        ) TOLL FREE NUMBER: (        )	33. DATE SENT TO WCB:  ____/____/____ MM   DD   YYYY
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**WCB-3 (10/98)** The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services or activities. This material can be made available in alternate formats by contacting your Department's ADA Coordinator.

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